McLAREN MEDICAL GROUP
CHILD/ADOLESCENT REGISTRATION

Language Preference: ☐ English
☐ Other specify: _____

PATIENT INFORMATION

PATIENT NAME (Last)	(First)	(Middle)	❑ Male ❑ Female
ADDRESS	CITY	STATE ZIP CODE	ETHNICITY: ❑ Hispanic/ Latino ❑ Non-Hispanic /Latino ❑ Decline to Answer ❑ Unknown
TELEPHONE ( )	SS# | | | — | | — | | | |	BIRTH DATE | | — | | — | | | |	RACE: ❑ Asian ❑ African American/ Black ❑ Caucasian/White ❑ Other ❑ Multi-Racial ❑ Decline to Answer
PRIMARY CARE PHYSICIAN	REFERRED OR RECOMMENDED BY		

PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN _____ **RELATIONSHIP**

NAME		
ADDRESS		
CITY	STATE	ZIP
TELEPHONE ( )	BIRTH DATE | | — | | — | | | |	
SS# | | | — | | — | | | |	CELL PHONE	
E-MAIL ADDRESS		
EMPLOYER	OCCUPATION	
EMPLOYER ADDRESS		
EMPLOYER TELEPHONE ( )	HOW LONG EMPLOYED	

PARENT/GUARDIAN _____ **RELATIONSHIP**

NAME		
ADDRESS		
CITY	STATE	ZIP
TELEPHONE ( )	BIRTH DATE | | — | | — | | | |	
SS# | | | — | | — | | | |	CELL PHONE	
E-MAIL ADDRESS		
EMPLOYER	OCCUPATION	
EMPLOYER ADDRESS		
EMPLOYER TELEPHONE ( )	HOW LONG EMPLOYED	

INSURANCE INFORMATION

PRIMARY INSURANCE		SUBSCRIBER	BIRTH DATE
ADDRESS		CITY STATE	ZIP CODE
POLICY #	GROUP #	EMPLOYEE ID#/SS#/MISC	GROUP NAME
INSURANCE COMPANY TELEPHONE ( )		PRE-CERTIFICATION TELEPHONE ( )	

SECONDARY INSURANCE		SUBSCRIBER	BIRTH DATE
ADDRESS		CITY STATE	ZIP CODE
POLICY #	GROUP #	EMPLOYEE ID#/SS#/MISC	GROUP NAME
INSURANCE COMPANY TELEPHONE ( )		PRE-CERTIFICATION TELEPHONE ( )	

OTHER INFORMATION

NEAREST RELATIVE NOT RESIDING AT SAME ADDRESS

NAME		RELATIONSHIP
ADDRESS	CITY STATE	ZIP CODE
WORK TELEPHONE ( )	HOME TELEPHONE ( )	
EMERGENCY CONTACT	RELATIONSHIP	TELEPHONE ( )

PARENT/LEGAL GUARDIAN SIGNATURE	**DATE**

UPDATES

DATE	SIGNATURE	DATE	SIGNATURE